HUMAN RESOURCES DEPARTMENT
127 East Oak Street, Juneau, WI53039 • 920-386-3690 • Fax 920-386-3545

MEDICAL CERTIFICATION - EMPLOYEE

Name of Dodge County Employee: _____

To the Health Care Provider: To determine whether the request meets the requirements of a "Serious Health Condition" under the family leave laws, please review the following and provide the requested information, as appropriate. THANK YOU!

Wisconsin State Statute, 103.10 (1)(g) defines "Serious Health Condition" as, a disabling physical or mental illness, injury, impairment or condition involving (1) inpatient care in a hospital, nursing home, or hospice, OR (2) outpatient care that requires continuing treatment or supervision by a health care provider.

Federal Family Medical Leave Act of 1993, 29 CFR Part 825, 114 defines a "Serious Health Condition" as an illness, injury, impairment, or physical or mental condition that involves:

- Any period of incapacity or treatment connected with inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility; or
- A period of incapacity requiring absence of more than three (3) calendar days from work, school, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a health care provider; or
- Any period of incapacity due to pregnancy, or for prenatal care; or
- Any period of incapacity (or treatment therefore) due to a chronic serious health condition (i.e. asthma, diabetes, epilepsy, etc.); or
- A period of incapacity that is permanent or long-term due to a condition for which may not be effective (i.e. Alzheimer's, stroke, terminal diseases, etc.);or
- Any absence to receive multiple treatments (including any period of recovery there from) by, or referral by, a health care provider for a condition that likely would result in incapacity of more than three (3) consecutive days if left untreated (i.e. chemotherapy, physical therapy, dialysis, etc.).

Health Care provider, please read the following and check the boxes as appropriate.

☐ The above named individual HAS a **serious health condition** as define above.

☐ The above named individual DOES NOT have a **serious health condition** as defined above.

Accordingly, I certify that this:

- The Health Condition commenced on (MUST BE COMPLETED): _____
- The Employee will be able to return to work on (MUST BE COMPLETED):_____
- The medical facts regarding the health condition are as follows (MUST BE COMPLETED): _____
  _____
- Please indicate the extent to which the employee is unable to perform his or her employment duties (MUST BE COMPLETED): _____
  _____

☐ Intermittent Leave/Reduced hours Leave: *Based on patient medical history and knowledge of medical condition please estimate treatment schedule and/or frequency of intermittent leave*:
____ times/week or ____ times/month
____ hours/day or ____ days/week

_____ Signature of Health Care Provider

_____ Name of Health Care Provider (Please Print)

_____ Address/City/State/Zip code

_____ Date

_____ Telephone Number